



Fax completed form to: (855) 840-1678  
 If this is an URGENT request, please call (800) 882-4462  
 (800.88.CIGNA)

# Givlaari (givorsiran)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician Name:			*Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed.*		
Specialty:	* DEA, NPI or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* Cigna ID:	* Date of Birth:	
Office Fax:			* Patient Street Address:		
Office Street Address:			City:	State:	Zip:
City:	State:	Zip:	Patient Phone:		
<b>Urgency:</b> <input type="checkbox"/> Standard <input type="checkbox"/> Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)					
<b>Medication Requested:</b> <input type="checkbox"/> Givlaari 189mg/ml vial			ICD10:		
Directions for use:	Dose:	Quantity:	Duration of therapy:		
What is your patient's current weight? _____ lb/kg					
<b>Where will this medication be obtained?</b> <input type="checkbox"/> Accredo Specialty Pharmacy** <input type="checkbox"/> PANTHERx Specialty Pharmacy <input type="checkbox"/> Other (please specify): _____					
**Cigna's nationally preferred specialty pharmacy					
**Medication orders can be placed with Accredo via E-prescribe - Accredo (1620 Century Center Pkwy, Memphis, TN 38134-8822   NCPDP 4436920), Fax 888.302.1028, or Verbal 866.759.1557					
<b>Facility and/or doctor dispensing and administering medication:</b> Facility Name: _____ State: _____ Tax ID#: _____ Address (City, State, Zip Code): _____					
Is the requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>					
<b>Clinical Information:</b> <b>What is the indication or diagnosis?</b> <input type="checkbox"/> Acute Hepatic Porphyria (AHP) <input type="checkbox"/> other indications and diagnoses: _____					
(if acute hepatic porphyria) Is the requested medication being prescribed by, or in consultation with, a gastroenterologist, hepatologist, or a physician who specializes in acute hepatic porphyria? <span style="float: right;">Yes <input type="checkbox"/> No <input type="checkbox"/></span>					
(if acute hepatic porphyria) Is documentation being provided that the patient has demonstrated clinical features associated with acute hepatic porphyria? PLEASE NOTE: Examples of clinical features associated with acute hepatic porphyria include neurovisceral symptoms, blistering lesions, hepatic involvement, peripheral neuropathy, abdominal pain, constipation, muscle weakness, pain in the arms and legs. Medical documentation specific to your response must be attached to this case or your request may be denied. Documentation may include, but is not limited to, chart notes, laboratory tests, claims records, and/or other information. All documentation must include patient-specific identifying information. <span style="float: right;">Yes <input type="checkbox"/> No <input type="checkbox"/></span>					

(if acute hepatic porphyria) Is documentation being provided that the patient has an elevated urinary aminolevulinic acid (ALA) greater than the upper limit of normal? PLEASE NOTE: Medical documentation specific to your response must be attached to this case or your request may be denied. Documentation may include, but is not limited to, chart notes, laboratory tests, claims records, and/or other information. All documentation must include patient-specific identifying information. Yes  No

(if no) Is documentation being provided that the patient has an elevated urinary porphobilinogen (PBG) greater than the upper limit of normal? PLEASE NOTE: Medical documentation specific to your response must be attached to this case or your request may be denied. Documentation may include, but is not limited to, chart notes, laboratory tests, claims records, and/or other information. All documentation must include patient-specific identifying information. Yes  No

(if acute hepatic porphyria) Prior to starting treatment with Givlaari, does the patient have a history of one porphyria attack in the last 6 months that required a hospitalization, urgent healthcare visit, or intravenous hemin administration at home? Yes  No

**Additional pertinent information:**

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

**Prescriber Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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*Our standard response time for prescription drug coverage requests is 5 business days. If your request is urgent, it is important that you call us to expedite the request. View our Prescription Drug List and Coverage Policies online at [cigna.com](http://cigna.com).*

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